COMMENTS to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9934-P

RE: HHS Notice of Benefit and Payment Parameters for 2018
Submitted by Community Catalyst
October 6, 2016

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) in response to the Notice of Benefit and Payment Parameters for 2018, released September 6, 2016.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments to the proposed Benefit and Payment Parameters for 2018, and we appreciate this administration's dedication to addressing these very important topics as we move into a time of transition from this administration to the next. While much attention has been paid to stabilizing the Marketplaces and encouraging issuer participation and competition for the future, we ask that HHS continue to prioritize access to affordable and quality care for consumers. Under the Affordable Care Act (ACA) we have made unprecedented coverage gains and we believe that continuing this success should be the priority moving forward. We believe continuing to provide meaningful access to coverage as well as strong consumer protections that ensure coverage is high quality and affordable will not only preserve the impressive coverage gains the ACA has made, but will also contribute to a robust and viable Marketplace.

Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

§ 147.102 – Fair Health Insurance Premiums

We generally support HHS' proposals related to child age rating. HHS has proposed one age band for children 0-14 years and additional bands for each year between 15 and 20. HHS has also proposed increasing the age rating factor for children up to age 14 from the current .635 to .765 and a gradual increase in the age factor year by year for ages 15 to 20.

We recognize the need to modify rates to reflect actual costs. However, these proposals will increase premiums for the approximately 1 million children enrolled in Marketplace coverage while also modulating the steep increase in premium costs at age 21 under the current rules. Although premiums will increase for families with children below 21, we recognize that HHS' proposal will make coverage moderately more affordable for young adults. Additionally, for individuals under 21, claims costs tend to be highest among ages 0-4. For children in this age range, health insurance is particularly significant because it provides access to screenings, immunizations and other important preventive care services. Establishing an age band from 0-14 will spread these initial costs over a broader risk pool thereby helping to ensure that children's coverage is more affordable when they need it most.

We recommend phasing in these proposed changes because they will result in higher premiums across the board. Although there are benefits to immediately smoothing the premium cliff at age 21, phasing in these new policies will help families adjust to the premium increases and create an opportunity for data collection. We specifically recommend that HHS collect data on the following: 1) the impact of premium increases on enrollment for individuals under 21; 2) whether smoothing the premium cliff increases the likelihood that individuals maintain coverage between 20 and 21; and 3) whether the utilization of additional age bands is an effective method of spreading claims risk across the child pool. We request that this data be made publicly available through a report promulgated by the Secretary and that the report include an analysis of HHS' child age rating proposals' impact on affordability and access to coverage for children and young adults.

§ 147.106 – Guaranteed Renewability of Coverage

a. Market Withdrawal Exception to Guaranteed Renewability Requirements

We recognize that striking a balance between a regulatory environment that encourages Marketplace participation and one that disincentives issuers from leaving the Marketplace is a challenge. Given the evolving nature of the 2017 Marketplaces, we support HHS' decision to align with state approaches to allow an issuer to transfer all of its products under a corporate reorganization to a related issuer, but where continuity of coverage is effectively provided, without triggering the 5-year ban. Similarly, we support HHS' proposal to allow an issuer to discontinue all of its products and offer all new products in the same market without triggering the 5-year ban on reentry. As HHS recognizes in the proposed rule, this scenario could allow an issuer to avoid the federal rate review process. We support HHS' decision to require issuers in this scenario to identify the new products that are replacing discontinued products and subject the new products to the federal rate review process. However, we ask HHS, in coordination with states, to carefully monitor this process so that this proposal doesn't become a vehicle for avoiding federal rate review, which is an important consumer protection.

b. Guaranteed Renewability in the Individual Market a and Medicare Eligibility

We recognize the tension between section 1882(d)(3) of the Social Security Act and the guaranteed renewability provision of the ACA under 45 CFR 147.106(h)(2) and appreciate that HHS is inviting feedback on how to interpret the two provisions together. Our enrollment

assister network frequently reports on the intricacies and challenges of helping current Marketplace enrollees' transition to Medicare in ways that avoid coverage gaps, overlaps, APTC repayment liabilities and Medicare late fees. Therefore, we believe new guidance on how these two provisions comport with one another will help enrollees transition to and maintain continuous, affordable coverage. To ensure current Marketplace enrollees can remain enrolled in coverage that both meets their health needs and budget, **we recommend that HHS interpret the guaranteed renewability provision as requiring insurers to renew a current Marketplace enrollee's coverage, even if the individual is eligible for or enrolled in Medicare**. However, since Marketplace enrollees receiving APTCs become ineligible to receive them once they become eligible for Medicare, we also recommend that HHS work with Marketplace insurers to notify current Marketplaces enrollees receiving APTCs of their 1) potential eligibility for Medicare, if they are turning 65 or are otherwise becoming eligible for Medicare; 2) their potential APTC repayment liability, if they are eligible for or enrolled in Medicare while receiving APTCs; and 3) how to transition to Medicare in ways to avoid gaps in coverage or APTC repayment liabilities.

F. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

§ 153.320 – Proposed Updates to the Risk Adjustment Model

We support the comments from the Center on Budget and Policies Priorities with regard to this section.

§ 153.610 – Risk Adjustment Issuer Data Requirements

We support the comments from the Center on Budget and Policies Priorities with regard to this section.

§ 153.630 – Data Validation Requirements when HHS Operates Risk Adjustment

We support the comments from the Center on Budget and Policies Priorities with regard to this section.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

§ 155.20 – Definitions

Overall, we are very supportive of the proposed 2018 plan year additions and modifications to standardized plan options and appreciate HHS' ongoing efforts to lesson consumers' burden when it comes to plan choice. We appreciate HHS' efforts to modify the standardized options to accommodate variation in state cost-sharing laws, but we encourage HHS to clarify that this policy is designed to create flexibility for state laws that improve, and do not undermine, standardized designs. We also encourage HHS to continue improving the standardized plan options based on enrollee and state experiences with the intention of requiring that standard plans

be offered in the future. We believe there are a few ways to meaningfully enhance these options for the 2018 plan year and beyond:

- We recommend that HHS make all of the standardized plans appear at the top of the Marketplace website or allow consumers to sort or filter these options.
- We recommend limiting the total number of nonstandard plans that insurers can offer, which is an idea with broad support in many state-based marketplaces. For instance, insurers in Oregon, Massachusetts, New York and Connecticut recognize that consumers may only look at the first couple pages while shopping for plan options, and limiting the number helps them more easily find the standardized plan that works best for them. A consumer survey in Massachusetts found that the optimal number of plans consumers wanted to choose among is three to five (although whether respondents were referring to insurers or their plans was unclear).

As proposed, the 2018 plan year will provide three sets of six standardized plan options. We continue to support the following components of the 2017 standardized plans: a single provider tier, fixed deductibles, fixed annual limitation on cost-sharing and fixed copayment or coinsurance for a key set of essential health benefits and holding certain EHBs exempt from the deductible, including rehabilitative and habilitative services. In addition to these key features, we applaud HHS for modifying these plans to account for state-level variations that promote better cost-sharing limits for consumers. In particular, the separate medical and drug deductibles at the silver and silver cost-sharing reduction variations is a feature that supports consumer access and adherence to needed medications.

However, we strongly recommend that HHS adopts the following element across all standardized options and metal levels within each option: require that all drug tiers carry a copayment rather than coinsurance so that medications do not become cost prohibitive for individuals with chronic conditions. All but one set of the 2018 proposed standardized options includes a coinsurance for the specialty drug tier, ranging anywhere from 25 to 50 percent depending on the metal level. A 2015 study on discriminatory benefit design defined adverse tiering – when issuers placed all drugs used to treat HIV on the highest cost-sharing tiers – using a cutoff of 30% coinsurance, which translated into an additional $3,000 annually for HIV positive beneficiaries.[1] In the event that HHS decides to keep a coinsurance, we recommend that HHS lowers the coinsurance to no higher than 20 percent. A lower coinsurance or using a copayment for specialty drugs does not impact the actuarial value (AV). According to an analysis by The California Department of Insurance, capping cost-sharing for higher tier drugs at $200 per prescription would have an impact of zero to .77 percent increase on premiums.[2] This policy to implement a cap on specialty drugs is in line with caps implemented by other states, including Maryland, Florida, Delaware, Louisiana and Montana – which all use a cap between $100 and $250 per prescription per month. **In addition to implementing copayments rather than coinsurance, we also recommend that HHS explores applying a per prescription drug copayment of $250 per month to the sets of standardized plan options.**

[1] Jacobs, Douglas and Benjamin Sommers. "Using Drugs to Discriminate—Adverse Selection in the Marketplace." N Engl J Med 2015; 372:399-402. January 29, 2015.

[2] http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/upload/nr041-CCdrugletter.pdf

Finally, we request HHS to continue monitoring the consumer experience in these plans for future standardized plan development: particularly how consumers find/access these plans and the implications of different cost-sharing designs in terms of access to care.

§ 155.205 – Consumer Assistance Tools and Programs of an Exchange

We are pleased that HHS continues to emphasize the importance of providing assistance to people with limited English proficiency (LEP) who need help with the application and enrollment process. Language access services have been critical to the success of millions of LEP consumers enrolling in coverage. However, we have concern over the aggregation of the top 15 languages across multiple states. In many states, this standard will not be useful for informing local LEP communities as each state has its own unique needs and will likely have different LEP population groups. For example, Hindi is not one of the top 15 languages nationally for individuals with limited English proficiency. However, when looking at state data, Hindi is one the top 15 languages in at least 7 states, including California, Texas and Illinois—three of the most populous states in the U.S.

We believe that a state-based methodology for threshold languages will best account for regional differences, maximize language efficiency and have the most targeted impact on individuals with LEP. Given the acknowledged difficulties in reaching non-English speaking consumers, and the lack of comprehensive data collection of applicants' and enrollees' language needs, taglines offer one of the least costly methods to help inform LEP individuals of their rights and the availability of in-language assistance. **Therefore, we strongly urge HHS to require that the taglines be made available in the top 15 languages spoken by limited English proficient persons *by state.*** This would not be overly burdensome or entail significant resources from a covered entity to use them since HHS provides sample taglines and state-by-state data of the top 15 languages. Additionally, given that entities such as issuers or brokers operating in more than one state likely have to tailor materials to the requirements of that state, and thus already create state-specific materials, requiring tailored state-specific taglines would not be an onerous requirement. We should err on the side of over-inclusion rather than under-inclusion to ensure adequate notice of available language services for those who need them.

We believe that Marketplaces (including HealthCare.gov), QHP insurers (including insurers in a group under common control) or web brokers that serve more than one state have the responsibility to post state-specific taglines. For example, a health insurance plan based in New Jersey that also operated in New York would have to post taglines for its New York consumers that included Yiddish, French and Urdu because those languages are in the top 15 non-English languages in New York, even though they are not in New Jersey. Adopting this standard balances being able to broaden the scope of covered languages included while ensuring a much larger proportion of LEP individuals in a service area are reached. If Marketplaces (including HealthCare.gov), QHP insurers (including insurers in a group under common control) or web brokers operate in multiple states, each of these entities could either include more than 15 taglines on one document used in multiple states or could have different documents in each state.

§ 155.220 – Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs

i. Differential Display of Standardized Options on the Websites of Agents and Brokers

We support HHS' decision to require web-brokers as well as issuers using direct enrollment pathways in the 2018 plan year to differentially display standardized plan options in a manner consistent with that adopted by HHS for display in the FFM, unless HHS approves a deviation. Since HealthCare.gov will be differentially displaying standardized plan options in plan year 2017 in a manner that makes it easier for consumers to find and identify them, we support requiring web-broker and other direct enrollment websites to align their display designs with HealthCare.gov by also differentially displaying standardized plans. Overall, we believe direct enrollment pathways should provide the same eligibility screening process and plan shopping experience as HealthCare.gov, so consumers are sufficiently informed that they are buying a Marketplace plan without being misled or deceived into thinking they are enrolling through HealthCare.gov. We understand HHS' decision to not require web-brokers and direct enrollment users to display standardized plans in an identical manner to HealthCare.gov, due to possible system constraints that may prohibit them from mirroring HealthCare.gov's format exactly. However, in reviewing design deviations, we ask that HHS consider whether the deviations will achieve the intended goals of the differential displays of standardized plans. In addition, we request that HHS limit the number or types of deviations to minimize consumer confusion and ensure there is as much consistency as possible in the Marketplace plan shopping experience. Lastly, we request that HHS not approve displays that may mislead or confuse consumers as to the type of plan they are purchasing and from whom they are purchasing the plan from. We support HHS' decision to evaluate whether the same level of differentiation and clarity is being provided under the deviation requested by web-broker or direct enrollment user as provided by HealthCare.gov.

ii. Enhanced Direct Enrollment Process

Overall, we support HHS' consideration of an enhanced direct enrollment process to support enrollment of consumers in Marketplace coverage because we believe in providing consumers with multiple options for their FFM enrollment experience and allowing the FFM to offer a diverse set of enrollment channels to reach consumers. We also appreciate HHS requesting comment on the necessary protections that need to be in place before fully moving forward with this enhanced process, and considering any additional risks that alternative enrollment channels may pose to consumer privacy and the security of consumer data. We ask that HHS ensure that enhanced direct enrollment process adequately notify and educate consumers about the nature of the process.

iii. Additional Protections for the Current Direct Enrollment Process and FFM Standard of Conduct of Agents and Brokers

We strongly support the proposed rule at § 155.220(c)(3)(i)(1) to require web-brokers to display information regarding the eligibility of advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs) in a prominent manner. We further support requiring direct enrollment pathways to allow consumers to input their desired amount of APTC and provide the required APTC-related attestations to their direct enrollment pathway application. We believe any application questions or information provided regarding APTC eligibility should be displayed in a clear, accessible and inviting manner so that consumers can be as adequately

informed about the availability and potential eligibility for financial assistance as they would be if enrolling through HealthCare.gov.

We also strongly support HHS' proposed rule at **§ 155.220(c)(3)(i)(K) to require the agents and brokers of record assist consumers with the post-enrollment activities necessary for the consumer to effectuate his or her coverage or resolve issues related to his or her enrollment.** Our organization has a network of over 4,700 enrollment assisters, such as Navigators and CACs, who have reported issues over the past three open enrollment periods with agents or brokers enrolling consumers in Marketplace plans without providing them with the information necessary to access or update their HealthCare.gov account information, thereby causing issues for consumers later down the road with maintaining their coverage or eligibility for financial assistance. For example, we received reports of agents or brokers creating HealthCare.gov account usernames and passwords for consumers when enrolling them, but not providing them with this information after the appointment. Additionally, we received reports of agents and brokers enrolling consumers in Marketplace plans with APTCs/CSRs, but not informing them of their ability and obligation to update their income, household and other information within 30 days to maintain accurate levels of financial assistance. Lastly, many consumers were unaware of their ability to shop around and switch their coverage through their account during open enrollment. Our experience from the field was further confirmed by our national partners at Kaiser Family Foundation in their annual survey of assisters and brokers, who found that agents and brokers were far less likely to offer post-enrollment support to consumers than Navigators or other in-person assisters. Therefore, **we recommend requiring agents and brokers to adequately educate consumers about their rights and responsibilities regarding their Marketplace plan, such as reporting any life changes within 30 days, resolving outstanding data-matching issues, and renewing their coverage at the end of the plan year**.

We also recommend that agents and brokers be required to receive training on Medicaid, CHIP, and Medicare, as well as how to help consumers successfully transition between Marketplace coverage and these forms of coverage. Our enrollment assister network has reported assisting a high number of individuals with transitioning between Marketplace coverage and Medicaid or Medicare. Therefore, we believe agents and brokers should be sufficiently trained in helping this population as well, such as by being trained on making referrals to in-person assister organizations. We also believe helping eligible consumers transition between these forms of coverage successfully should be a required post-enrollment activity because it will maintain program integrity as well as avoid APTC repayment liabilities for consumers.

Lastly, we support requiring web-brokers, agents and brokers to refrain from using a website that could potentially mislead consumers into believing they are visiting HealthCare.gov. We believe that web-brokers should both adequately inform consumers that they are buying a Marketplace plan, while also not misleading them into thinking they are enrolling through HealthCare.gov. We recommend that in determining whether a particular web site is misleading, HHS take into consideration whether or how the website notifies consumers that it is not HealthCare.gov, such as through pop-messages or other textual or visual displays.

§ 155.240 – Payment of Premiums

We strongly support HHS considering rules that would allow consumers to receive refunds of any electronic fund transfers or withdrawals of premiums if a consumer stops receiving APTCs/CSRs and is billed a much larger premium the following month as a result. Our enrollment assister network has reported working with consumers who have experienced financial stress or burdens as a result of an automatic withdrawal of an unanticipated larger premium amount. Enrollment assisters have also reported that APTC-eligible population in their state or region often consists of consumers who often have fluctuating and unpredictable incomes. Therefore, experiencing a larger-than-anticipated automatic bank withdrawal can have dire financial consequences. Therefore, we believe federal rulemaking in this area would protect many consumers from financial hardship. Specifically, requiring refunds of EFTS as well as grace periods to make the full premium payment would both protect consumers from financial hardship as well as allow them to continue receiving coverage and care.

§ 155.330 – Redetermination during a Benefit Year

Overall, we support the proposed rules allowing Marketplaces to choose alternative procedures for conducting eligibility redeterminations, periodic data-matching of an enrollee's requirement to file and reconcile APTCs, and recalculations of APTCs after a redetermination, to better account for differences in Marketplace systems and to mitigate complexities. We also support conditioning HHS approval on a showing by the Marketplace that the alternative procedures would provide adequate program integrity protections, minimize administrative burdens and limit negative impacts on consumers.

§ 155.400 – Enrollment of Qualified Individuals into QHPs

We strongly support the proposed rule to give Marketplaces discretion to allow issuers to implement reasonable extensions of binder payment deadlines if the issuer experienced billing or enrollment problems. We believe providing rulemaking on binder payment extension deadlines in these situations appropriately balances issuer flexibility with consumer protectiveness.

§ 155.420 – Special Enrollment Periods

We appreciate the opportunity to weigh in on the potential impact of SEP eligibility verification procedures on enrollment, continuity of coverage and risk pools. Community Catalyst works with a network of over 4,700 enrollment assisters who report on a daily basis about their experience helping consumers enroll in Marketplace coverage. Throughout the past three open enrollment periods, our assister network has never reported working with a consumer who attested to, or who they believed may have enrolled through a special enrollment period in a fraudulent manner. Therefore, it is difficult for us to assess whether or which SEPs have been prone to abuse. While we understand that there are concerns about the abuse of the SEP process, we are concerned that creating any potential barriers to enrollment, such as through a pre-enrollment verification process, may in fact delay the ability of eligible individuals to access needed coverage and care, thereby causing them to join the risk pool in a less healthy state than they initially could have or ultimately discourage enrollment of healthy individuals. Additionally, we are unable to fully weigh the impact of any potential verification process

without first understanding the magnitude and details of the problem it aims to address through a full review of the data, which remains unavailable at this time. **Therefore, we ask that HHS releases data illustrating the extent of any SEP abuse so that we may be better positioned to provide feedback on how to curb this abuse.**

§ 155.430 – Termination of Exchange Enrollment or Coverage

We support the proposed rule to require insurers, prior to rescinding an enrollee's coverage, to provide sufficient information to the Marketplace that its rescission is appropriate, since the Marketplace must be involved in all aspects of the enrollment process, including rescissions and other terminations. We also believe it is important for consumer protection and the viability of the Marketplaces that an eligible enrollee does not have coverage rescinded without a sufficient showing that the enrollment was fraudulent or due to intentional misrepresentations of material fact.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

§ 156.140 – Levels of Coverage

We strongly support HHS' proposal to provide more flexibility for insurers in the design of bronze plans by redefining the de minimis variation. As HHS states in the proposal, the purpose of this change is to allow bronze plans to remain at least as generous as catastrophic plans and offer certain services before the deductible while still meeting the actuarial value requirements. Given that the cost burden of high deductible plans leads to many consumers delaying or forgoing necessary care, giving issuers more flexibility to offer services before the deductible is critical to promoting access to necessary care for consumers. We support HHS' proposal for the major services covered and paid for by the plan before the deductible that would trigger the increased de minimis range, including: primary care visits, specialist visits, inpatient hospital services, generic, specialty, or preferred branded drugs or emergency room services.

We appreciate that HHS seeks comment on what a reasonable cost-sharing level is for these major services offered pre-deductible. In many ways, what is reasonable and thereby affordable to a consumer is highly subjective and influenced by personal circumstances. In some cases, any cost-sharing associated with a plan could result in a consumer delaying or skipping necessary care. HHS should consider the following in assessing cost-sharing levels for these plans:

- If possible, while still adhering to the actuarial value standards, cost-sharing should be in the form of a co-payment instead of coinsurance, as coinsurance makes it very difficult to predict the actual cost to the consumer.
- At the very least, cost-sharing levels should be no higher than the levels applied to the 2018 standardized plan options.

§ 156.200 – QHP Issuer Participation Standards

We strongly support HHS' proposal to require issuers to offer at least one silver and one gold QHP in each service area in which the issuer offers coverage through the

Marketplace. As indicated in the proposed rule, this clarification will prevent an issuer from offering a gold and silver plan in one service area but only offering bronze and catastrophic coverage in the remaining service areas in a state. This clarification is important for promoting plan options for consumers, but it is especially important for protecting sicker patients from adverse selection and insurers designing plans to avoid less healthy, more costly enrollees. Without this protection, an issuer could choose to only offer a bronze plan in a particular service area to attract healthier enrollees who can afford a higher deductible; forcing sicker and costlier enrollees to choose a silver plan offered by another issuer.

§ 156.230 – Network Adequacy

We are disappointed there will not be additional requirements for network adequacy in 2018. **We strongly urge HHS to set specific quantitative access standards HHS will use to evaluate whether QHP provider networks are adequate**, at least in areas where consumers have historically experienced access problems, including mental health providers, oncology providers and primary care providers. As we explained in great detail in our comments to the proposed 2017 Notice of Benefit and Payment Parameters[3] as well as the draft 2017 Letter to Issuers[4], these minimum quantifiable network adequacy thresholds will do a great service in creating a minimum, commonly understood definition of network adequacy across insurers within a given state, and consumers can have confidence that their plan options must meet a clear, measurable definition of network adequacy.

We appreciate that HHS has developed a system for rating network breadth. With the growth of narrow networks and lack of out-of-network coverage, it is critically important that consumers understand the network that comes with the plan they are choosing and the trade-offs that come with that choice. However, we are disappointed that the network breadth system will only pilot in four states.

In terms of specific indicators to calculate network breadth, **we urge HHS to consider the following categories of provider classifications in addition to hospitals, adult primary care and pediatric primary care:**

- Emergency Department physicians who practice at an in-network hospital;
- Adult physician specialists (non-Emergency Department physicians, such as anesthesiologists and pathologists) who practice at an in-network hospital;
- Adult specialists who practice in office-based settings, such as cardiologists and psychiatrists;
- Pediatric specialists; and
- Essential community providers.

[3] Comments to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9937-P, December 21, 2015, available at: http://www.communitycatalyst.org/resources/comment-letters/document/Community-Catalyst-Comments-CMS-9937-P.pdf

[4] Comments to the Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Service, January 15, 2016, available at: http://www.communitycatalyst.org/resources/comment-letters/document/Community-Catalysts-comments-2017-Draft-Issuer-Letter-1.15.16.pdf

The additional categories would give consumers a better understanding of their ability to access needed care. This is especially true for consumers with chronic illnesses who will find it very helpful to have an understanding of their plan's network breadth with respect to specialty care. In addition, HHS should consider expanding the categories of specialists so that consumers with particular conditions can obtain rating information on different aspects of their care. We also recommend that HHS use a broad set of providers as the denominator when calculating the Provider Participation Rate, instead of using only the total number of providers contained in QHP networks. Such an approach would give consumers a more accurate picture of a network's ability to meet their health care needs. Finally, **we strongly urge HHS to conduct consumer testing to inform which terminology to use and how best to display this information for the public so that the network breadth indicators are meaningful and useful to consumers**.

We continue to have concerns about the 2017 Payment Notice requirements intended to limit enrollees' exposure to out-of-network costs. First, while we support the requirement that QHP issuers count an EHB benefit provided by an out-of-network provider at an in-network facility toward the enrollee's annual limitation on cost sharing in certain circumstances, we believe that this protection is practically meaningless given an issuer's ability to avoid limiting the enrollee's financial exposure by sending a notice. While we recognize that notice is an excellent first step toward protecting consumers, it is not sufficient by itself. More should be done to address the underlying issue of adequate networks to protect enrollees from out-of-network costs, which we address in the next section. **We recommend the following with respect to the 2017 Payment notice requirements:**

- Any additional charges that an enrollee incurs as the result of receiving care at an in-network facility by an out-of-network ancillary provider should count towards the enrollee's annual out of pocket spending limits, regardless of notice.

- Notices to enrollees should be required and should include an explanation of what steps an enrollee can take to ensure that services are provided by an in-network or first tier provider. HHS should clarify that QHP issuers cannot comply with a notice requirement by simply providing a form notice to consumers. Rather, issuers must be required to provide a notice customized to each consumer's situation in order to provide the consumer with a real and meaningful opportunity to avoid a surprise bill and ensure that all of their care is provided by first tier or in-network providers. Anything less does not provide consumers with any real assurance of network adequacy.

- To address the underlying issue of adequate networks, HHS should make clear that QHP issuers must ensure that their networks are adequate to ensure that all covered services are available from in-network or first tier providers and that consumers may not be held liable for costs associated with out-of-network or higher tier providers from whom they did not elect to receive services. If a QHP is not able to ensure that an enrollee has the option to choose in advance of receiving services to receive care only from in-network providers, the QHP must not permit any out-of-network providers to bill the consumer.

- Finally, with the addition of the revisions mentioned above, we support HHS' proposal to apply these requirements to QHPs both on and off the Marketplace, regardless of whether the QHP covers out-of-network services.

We thank HHS for its commitment to continue to monitor issues relating to "surprise bills" for consumers. We believe that this is an ongoing issue of affordability and should remain a top priority for federal and state regulators. **We strongly believe that enrollees should not be subject to out-of-network cost sharing in cases when they could not be reasonably expected to know or control whether care is being delivered by out-of-network providers.** These situations include, but are not limited to:

- Unavailability of in-network providers for a covered EHB;
- Unexpected utilization of out-of-network care for a covered EHB;
- Emergency care;
- Unexpected utilization of out-of-network care as a result of an inaccurate provider directory**.**

In addition, to truly demonstrate that QHP networks are adequate, HHS should require QHP issuers to ensure that enrollees always have the option to use an in-network or first tier provider for all covered services. If a QHP is not able to secure an in-network or first tier provider for a particular service or guarantee that an in-network or first tier provider will be used, the enrollees cannot be held liable for any excess cost-sharing or bills beyond the amount the consumer would pay if the service had been provided by an in-network provider.

§ 156.235 – Essential Community Providers

We appreciate HHS' continued emphasis on ensuring that QHP networks include essential community providers (ECPs). However, we are disappointed that the ECP standard has not been improved since 2016. Especially, in a geographically large rural county, one health center located in a corner of the county may not be accessible for those who reside on the other side of the county. Minimal standards on ECP inclusion will fail to ensure reasonable and timely access to care for low-income and medically underserved individuals and their families. We call on HHS to considerably strengthen and clarify the ECP standard in key ways to ensure provider networks are sufficient to meet consumers' needs as they enter the Marketplace. **HHS should consider increasing the 2018 threshold from 30 percent to at least 50 percent of ECPs in a plan's service area, especially in Health Professional Shortage Areas or five-digit zip codes in which at least at least 30 percent of the population falls below 200 percent of the Federal Poverty Line.**

We strongly urge HHS to clarify that issuers must include in their QHP networks (not simply offer a contract) at least one ECP in each category and in each county in the service area. The ECP percentage threshold helps enable access to ECPs overall, but it does nothing to ensure patient access to a broad range and distribution of ECP provider types. The ECP categories are distinct in important ways. ECP categories – such as family planning providers, Ryan White providers, Indian Health providers and ECP hospitals – often provide specific services tailored to meet the needs of certain populations or sub-populations. In addition, we strongly urge CMS to expand the ECP categories to include:

- Substance use disorders treatment and recovery services providers, and community mental health providers; and

- Pediatric providers inclusive of pediatric specialists and subspecialists. In addition, children's hospitals should be disaggregated from other types of ECP hospitals to ensure QHP provider networks are sufficient to meet children's needs.

We also recommend that at least 90% of beneficiaries have access to a participating hospital which has a capacity to serve the entire enrolled population based on normal utilization, and, if separate from such hospital, a provider of all emergency health care services within 60 minutes or 30 miles.

HHS should implement robust monitoring and enforcement of the ECP standards to protect access to ECPs in QHP networks throughout the coverage year. Specifically, we believe HHS should do the following:

- Continue to assess provider networks and monitor QHP contracting to identify patient access and narrow network concerns;
- Require issuers to offer contracts to additional ECPs at any point during the year to ensure patients have adequate access to health services;
- Monitor QHP contracting to ensure that issuers do not discriminate against ECPs through contract negotiations and to make sure contracts are offered in good faith; and
- At a minimum, monitor compliance and make public issuer narrative justifications that describe how the issuer's provider network that fails to meet the ECP minimum threshold provides enrollees with access to services.

HHS seeks comments on changes to the counting of hospital ECPs for the 2019 benefit year and best approach for measuring hospital participation. We encourage HHS to disaggregate children's hospitals from the ECP "hospital" category when calculating hospital participation. Children's hospitals have unique capabilities and expertise. Disaggregating children's hospitals from other hospitals will help ensure that issuers will contract with entities that can provide the specialized care that children need.

§ 156.272 – Issuer Participation for Full Year

We strongly support HHS' proposal to require as a condition of QHP certification that QHP issuers in all Marketplaces must make their QHPs available for enrollment through the Marketplace for the entire plan year for which the plan was certified, unless there is a basis for suppression under current law. This proposal is critical to ensuring adequate plan choice for enrollees who enroll using an SEP outside of open enrollment. Additionally, this provision will add greater stability to the Marketplaces, barring a reason for suppression of a plan.

§ 156.290 – Non-Certification and Decertification of QHPs

We strongly support HHS' proposal to require a QHP issuer to provide notice to an enrollee if the issuer is denied certification for a subsequent, consecutive certification cycle for a plan. This proposal aligns the notice requirements, as QHP issuers are already required to provide notice if the issuer elects to not seek certification for a plan in a subsequent, consecutive certification cycle. We applaud HHS for addressing this discrepancy and making sure that all

QHP enrollees receive notification that will allow them to prepare to participate in a future open enrollment period.

§ 156.50 – FFM User Fee

We support HHS' proposal to consider designating a specific portion of the FFM user fee to be allocated directly to outreach and education activities, as we believe there is still a critical need for strong financial and operational support for outreach and enrollment activities. We recommend that when considering the amount of user fees to dedicate to outreach efforts, HHS consults with enrollment stakeholders such as in-person assister organizations, community-based organizations and consumer health advocates to determine several outreach best practices and the requisite amount of funding they would take to implement. We also ask that HHS take into consideration the number of remaining uninsured individuals who are eligible for Marketplace coverage in each state, as well as the capacity and effectiveness of Navigators and other in-person assisters in each state, when determining the amount of user fees to dedicate to outreach efforts in each respective marketplace.

Respectfully submitted,

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